uterine manipulation. We have documented profound maternal sensitization following incomplete spontaneous abortion at 12 weeks followed by dilatation and curettage.

RhoGam should be given in indicated cases within 72 hours of delivery or termination of pregnancy, after proper cross-matching with the mother's blood. If the patient refuses RhoGam for any reason, suitable medicolegal documentation of such refusal should be carried in the patient's record. RhoGam should be repeated following each Rh positive or Rh unknown pregnancy, provided the Rh negative mother has not been previously sensitized by pregnancy or blood administration.

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Squamous Dysplasia of the Uterine Cervix

There is evidence that squamous neoplasia of the uterine cervix progresses from squamous dysplasia to carcinoma in situ, microinvasive carcinoma, and infiltrative carcinoma.

The evidence for progression is by: (1) clinical observation in one-third of cases, dysplasia when untreated progresses to intraepithelial carcinoma over a five-year period; (2) DNA content of the nuclei of the involved epithelium (the percent of aneuploid cells rises progressively through the four stages); and (3) growth characteristics in tissue culture (the observed repelling characteristic of cells in monolayer cultures increases from dysplasia through infiltrative carcinoma).

Cervical dysplasias present special problems for clinicians. Generally there is no gross lesion visible; most often, a Class III cervical cytology report is the first sign of its presence. Occasionally the colposcopist or colpomicroscopist will observe the epithelial change. Most often the clinician will take a biopsy specimen from the squamocolumnar junction and proceed to cervical conization to define the extent of the change and to rule out invasive cancer.

Cytologists and colposcopists are able accurately to predict about 60 percent of dysplasias as later identified by histologic verification. Eventually the diagnosis must be made by histologic sections. The most complete histologic appraisal is the full cervical conization and this diagnostic procedure generally rules out invasive cancer, and serves for treatment.

If invasive or intraepithelial cancer could be excluded with relative certainty by procedure less extensive than surgical conization, a substantial amount of morbidity could be avoided. To this end, the colposcope, the endocervical curettage, and the four quadrant directed biopsies have been utilized. Reliance on this outpatient diagnostic appraisal requires identification of a transformation zone, a cervical canal capable of allowing endocervical curettage (ECC), and a willingness to proceed to conization if these fail.

Treatment rests on these assumptions: (1) if neoplasia is present, it will be present in the squamocolumnar junction; and (2) if the squamocolumnar junction and abnormal areas of the exocervix show only dysplasia and if the endocervical curettage is negative, intraepithelial or infiltrative carcinoma are excluded. It is generally true in postmenopausal women that the transformation zone is not visualized by colposcopy and the cervical canal is difficult to currette. Consequently a postmenopausal woman is not definitively evaluated in an outpatient department.

Once squamous dysplasia has been established and more advanced neoplasia excluded, under controlled conditions treatment may rest at: (1) electrocautery; (2) cryosurgery; (3) cervical conization (preferred). Hysterectomy is generally not indicated for squamous dysplasia alone.

In view of the malignant potential of squamous dysplasia, all patients require periodic follow-up with cytologic screening following treatment.

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